# Row 10410

Visit Number: f5e20a9e52d532b778eacf8fdf7950c7e5dd2d2e479045b54cbe061495ca841a

Masked\_PatientID: 10406

Order ID: 599a9700056a800d0348702e7a7bde83d0ee8a9d3e57cf5f6aad6a3296482a34

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 21/7/2017 17:18

Line Num: 1

Text: HISTORY Worsening LFTS TRO LIVER abscess and for restaging TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 55 FINDINGS Comparison is made previous CT of 29 June 2017 Status post Whipple surgery. Following placement of the PTC drainage catheter (via segment 8/4) with the distal end within the proximal jejunostomy, the intrahepatic ducts that were dilated are now decompressed (with residual dilatation) and with aerobilia. Furthermore, this cluster of liver abscesses in segment five is almost completely resolved with just a residual 1.3 x 1.3 cm focus. No definite new focal liver parenchymal lesion is detected. The remnant pancreas appearing to anastomose to the stomach is grossly atrophic with mild dilatation of the main pancreatic duct. There is abnormal soft tissue on the right side of the proximal SMA and likely encasing the main vessel lumen, in contact with the coeliac bifurcation raises possibility of cancer recurrence. Some borderline enlarged adenopathy is seen inferiorly in small bowel mesentery adjacent to the main trunk of the SM vessels. These appear more slightly more prominent. Adenopathy in the supraceliac region appears larger as well, now measuring about 1.7 cm ( series eight image 29). There is also soft tissue encasing the splenic vein and upper SMV and confluence as well as the main portal vein takeoff, narrowing the vessel lumen,suspicious for cancer recurrence, clearly larger than in July 2015. The spleen is top normal size. Oesophageal varices are present. The adrenals and both kidneys are unremarkable. The bladder and the bowel shows no gross abnormalitiesalthough there are small amounts of ascites more evident in the pelvic cavity. Small volume para-aortic lymph nodes are noted. No enlarged pelvic lymph nodes. No enlarged hilar or mediastinal lymph nodes. No pleural or pericardial effusion. Both lungs are grossly unremarkable. The bone settings show no destructive lesion. CONCLUSION Since June 2017, the indwelling PTC catheter has decompressed the obstructed biliary system, although residual dilatation remains. If still suspicious for obstruction, direct cholangiography via the indwelling catheter may be useful. The preexisting liver abscess has nearly resolved completely. In the short term, the cancer recurrence around the root of the mesentery and splenoportal venous axis is mostly stable other than worsening enlargement of adenopathy in the supraceliac station and within the small bowel mesentery more inferiorly. May need further action Finalised by: <DOCTOR>

Accession Number: 2a3d1350ad52f0efc218e2d9b3fb45abd5123a57f1821bec15025c5276ca5ca6

Updated Date Time: 21/7/2017 18:30